Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ST DAVIDS MEDICAL CENTER
3701 KIRBY DR STE 1288
HOUSTON TX 77098-3916

Respondent Name
WAL MART ASSOCIATES INC

Carrier's Austin Representative Box
Box Number 53

MFDR Tracking Number
M4-11-4937-01

MFDR Date Received
August 25, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In closing, it is the position of the Provider that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions taken by the Carrier in this case. The Carrier's position is incorrect and in violation of Rule §134.403."

Amount in Dispute: $5,117.29

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This payment dispute is represented as a MEDICAL FEE DISPUTE. However, carrier review finds this to be predominantly a PPO CONTRACT dispute. Contract verification with RockPort confirms reduction of $4726.19 was incorrectly applied in accordance with outdated contract. This reduction is now retracted & $4726.19 IS NOW REIMBURSED TO PROVIDER."

Response Submitted by: Claims Management, Inc., P.O. Box 1288, Bentonville, AR 72712-1288

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 31, 2010 to September 1, 2010	Outpatient Hospital Services	$5,117.29	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated October 21, 2010

- 11 – THE RECOMMENDED ALLOWANCE FOR THE SUPPLY WAS BASED ON THE ATTACHED INVOICE.
- 13 – AN ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED FOR IMPLANTS/PROSTHETICS.
- 45 – CHARGES EXCEED YOUR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
- 97 – PAYMENT ADJUSTED BECAUSE THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED).
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
- 243 – THE CHARGE FOR THIS PROCEDURE WAS NOT PAID SINCE THE VALUE OF THIS PROCEDURE IS INCLUDED/BUNDLED WITHIN THE VALUE OF ANOTHER PROCEDURE PERFORMED.
- 285 – PLEASE REFER TO THE NOTE ABOVE FOR A DETAILED EXPLANATION OF THIS REDUCTION.
- 799 – ALLOWANCE HAS BEEN ADJUSTED IN ACCORDANCE WITH OPPS MULTIPLE PROCEDURE RULE.
- 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE.
- 954 – THE ALLOWANCE FOR NORMALLY PACKAGED REVENUE AND/OR SERVICE CODES HAVE BEEN PAID IN ACCORDANCE WITH THE DISPERSED OUTPATIENT ALLOWANCE.
- 5036 – COMPLEX BILL – REVIEWED BY MEDICAL COST ANALYSIS TEAM –UR/UE.

Explanation of benefits dated April 26, 2011

- 11 – THE RECOMMENDED ALLOWANCE FOR THE SUPPLY WAS BASED ON THE ATTACHED INVOICE.
- 13 – AN ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED FOR IMPLANTS/PROSTHETICS.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.
- 285 – PLEASE REFER TO THE NOTE ABOVE FOR A DETAILED EXPLANATION OF THIS REDUCTION
- 799 – ALLOWANCE HAS BEEN ADJUSTED IN ACCORDANCE WITH OPPS MULTIPLE PROCEDURE RULE.
- 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWANCE.
- 954 – THE ALLOWANCE FOR NORMALLY PACKAGED REVENUE AND/OR SERVICE CODES HAVE BEEN PAID IN ACCORDANCE WITH THE DISPERSED OUTPATIENT ALLOWANCE.
- 1001 – BASED ON THE CORRECTED BILL AND/OR ADDITIONAL INFORMATION/DOCUMENTATION NOW SUBMITTED BY THE PROVIDER. WE ARE RECOMMENDING FURTHER PAYMENT TO BE MADE FOR THE ABOVE NOTED PROCEDURE CODE.
- 5036 – COMPLEX BILL – REVIEWED BY MEDICAL COST ANALYSIS TEAM –UR/UE.

Explanation of benefits dated July 4, 2011

- 11 – THE RECOMMENDED ALLOWANCE FOR THE SUPPLY WAS BASED ON THE ATTACHED INVOICE.
- 13 – AN ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED FOR IMPLANTS/PROSTHETICS.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.
- 799 – ALLOWANCE HAS BEEN ADJUSTED IN ACCORDANCE WITH OPPS MULTIPLE PROCEDURE RULE.
- 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWABLE.

- 5036 – COMPLEX BILL – REVIEWED BY MEDICAL COST ANALYSIS TEAM – UR/UE.

Explanation of benefits dated September 9, 2011

- 11 – THE RECOMMENDED ALLOWANCE FOR THE SUPPLY WAS BASED ON THE ATTACHED INVOICE.
- 13 – AN ADDITIONAL ALLOWANCE HAS BEEN RECOMMENDED FOR IMPLANTS/PROSTHETICS.
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
- W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.
- 170 – REIMBURSEMENT IS BASED ON THE OUTPATIENT/INPATIENT FEE SCHEDULE.
- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME.
- 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPS SCHEDULE ALLOWABLE.
- 954 – THE ALLOWANCE FOR NORMALLY PACKAGED REVENUE AND/OR SERVICE CODES HAVE BEEN PAID IN ACCORDANCE WITH THE DISPERSED OUTPATIENT ALLOWANCE.
- 1001 – BASED ON THE CORRECTED BILLING AND/OR ADDITIONAL INFORMATION/DOCUMENTATION NOW SUBMITTED BY THE PROVIDER. WE ARE RECOMMENDING FURTHER PAYMENT TO BE MADE FOR THE ABOVE NOTED PROCEDURE CODE.
- 5036 – COMPLEX BILL – REVIEWED BY MEDICAL COST ANALYSIS TEAM –UR/UE.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.

2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables in accordance with subsection (g). Review of the submitted documentation finds no request for separate reimbursement of implantables. Nor did the requestor certify that the amount billed represents the actual costs for the implantables in accordance with §134.403(g)(1). Reimbursement will therefore be calculated at 200 percent of the Medicare facility specific reimbursement amount, including any outlier payments, as specified in §134.403(f)(1)(A).

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code C1820, date of service September 1, 2010, has a status indicator of N , which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code C1897, date of service September 1, 2010, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 80048, date of service August 31, 2010, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code

§134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $12.12. 125% of this amount is $15.15. The recommended payment is $15.15.

- Procedure code 85730, date of service August 31, 2010, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $8.60. 125% of this amount is $10.75. The recommended payment is $10.75.
- Procedure code 85610, date of service August 31, 2010, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $5.62. 125% of this amount is $7.02. The recommended payment is $7.02.
- Procedure code 85025, date of service August 31, 2010, has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.14. 125% of this amount is $13.93. The recommended payment is $13.93.
- Procedure code 63685, date of service September 1, 2010, has a status indicator of S , which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0039, which, per OPPS Addendum A, has a payment rate of $13,892.45. This amount multiplied by 60% yields an unadjusted labor-related amount of $8,335.47. This amount multiplied by the annual wage index for this facility of 0.9515 yields an adjusted labor-related amount of $7,931.20. The non-labor related portion is 40% of the APC rate or $5,556.98. The sum of the labor and non-labor related amounts is $13,488.18. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $13,488.18 divided by the sum of all S and T APC payments of $19,150.25 gives an APC payment ratio for this line of 0.704334, multiplied by the sum of all S and T line charges of $4,278.00, yields a new charge amount of $3,013.14 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,175, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.201. This ratio multiplied by the billed charge of $3,013.14 yields a cost of $605.64. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $13,488.18 divided by the sum of all APC payments is 70.43%. The sum of all packaged costs is $23,141.15. The allocated portion of packaged costs is $16,299.11. This amount added to the service cost yields a total cost of $16,904.75. The cost of these services exceeds the annual fixed-dollar threshold of $2,175. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this line is $13,488.18. This amount multiplied by 200% yields a MAR of $26,976.36.
- Procedure code 63655, date of service September 1, 2010, has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0061, which, per OPPS Addendum A, has a payment

rate of $5,831.77. This amount multiplied by 60% yields an unadjusted labor-related amount of $3,499.06. This amount multiplied by the annual wage index for this facility of 0.9515 yields an adjusted labor-related amount of $3,329.36. The non-labor related portion is 40% of the APC rate or $2,332.71. The sum of the labor and non-labor related amounts is $5,662.07. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $5,662.07 divided by the sum of all S and T APC payments of $19,150.25 gives an APC payment ratio for this line of 0.295666, multiplied by the sum of all S and T line charges of $4,278.00, yields a new charge amount of $1,264.86 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $2,175, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.201. This ratio multiplied by the billed charge of $1,264.86 yields a cost of $254.24. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $5,662.07 divided by the sum of all APC payments is 29.57%. The sum of all packaged costs is $23,141.15. The allocated portion of packaged costs is $6,842.04. This amount added to the service cost yields a total cost of $7,096.28. The cost of these services exceeds the annual fixed-dollar threshold of $2,175. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this line is $5,662.07. This amount multiplied by 200% yields a MAR of $11,324.14.

4. The total allowable reimbursement for the services in dispute is $38,347.35. This amount less the amount previously paid by the insurance carrier of $48,392.32 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	March 21 , 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.